MEDICAL RECEIVING - SCREENING

DATE AND TIME BOOKED	NAME	X REF NO.

RACE	SEX	SOCIAL SECURITY NO.	D.O.B. / /	NEXT OF KIN

CHARGES	NEXT OF KIN'S PHONE NO.

OFFICER'S OBSERVATIONS

Does the prisoner appear to be:

☐ YES ☐ NO (1.) Mentally retarded or exhibiting hearing or speech problems?
☐ YES ☐ NO (2.) Suffering limited movement? (WHY) _____
☐ YES ☐ NO (3.) Under the influence of alcohol or drugs?
☐ YES ☐ NO (4.) Infested with lice or crabs?
☐ YES ☐ NO (5.) A danger to self or others?
☐ YES ☐ NO (6.) Disoriented, confused, impaired level of consciousness?
(7.) Check all that apply:

☐ Sweaty ☐ Shaking ☐ Alcohol on Breath
☐ Calm ☐ Deep Yellow Skin or Eyes ☐ Bleeding (specify) _____
☐ Sleepy ☐ Agitated ☐ Deformities(specify) _____
☐ Cuts, Bruises, Needle marks (specify) _____ ☐ Persistent Cough
☐ Other: _____

ARRESTEE'S HEALTH HISTORY

☐ YES ☐ NO (1.) Have you ever tried to harm yourself?
☐ YES ☐ NO (2.) Are you thinking of harming yourself now?
☐ YES ☐ NO (3.) Do you hear voices?
☐ YES ☐ NO (4.) Do you have problems with mood swings or depression?
☐ YES ☐ NO (5.) Are you currently receiving psychiatric treatment?
☐ YES ☐ NO (6.) Have you been a patient in a mental hospital within the past 5 years?
☐ YES ☐ NO (7.) Have you ever been treated at a regional center or diagnosed with developmental problems?
☐ YES ☐ NO (8.) Have you ever been treated for tuberculosis?
☐ YES ☐ NO (9.) Have you had a cough for more than three weeks with any of the following: fever, weight loss, fatigue, night sweats?
☐ YES ☐ NO (10.) Have you recently been in contact with someone who has tuberculosis?

(11.) Do you currently have any of the following conditions? *(INDICATE YES WITH AN X)*

( ) High blood pressure	( ) Seizures	( ) Tuberculosis	( ) Skin Condition
( ) Heart problems	( ) Asthma	( ) Psychiatric	( ) Gonorrhea
( ) Diabetes	( ) Hepatitis	( ) Syphilis	( ) Herpes
( ) Dental problems	( ) Allergies	( ) Deformities	( ) AIDS

☐ YES ☐ NO (12.) Do you have any other medical problems/injuries? (specify) _____
☐ YES ☐ NO (13.) Do you take any medications? (type/dose) _____
☐ YES ☐ NO (14.) Are you allergic to any medications? (type) _____
☐ YES ☐ NO (15.) Are you wearing contacts, prosthesis, casts, using crutches?
☐ YES ☐ NO (16.) Have you had a recent head injury/traffic accident/fight?
☐ YES ☐ NO (17.) Do you have any drug/alcohol use that could cause withdrawal problems?
a. Type/amount used daily? _____
b. Time of last does or drink? _____
☐ YES ☐ NO (18.) Medical treatment prior to incarceration? Medi-Cal or Insurance? _____

FEMALE ONLY

☐ YES ☐ NO (1.) Are you taking birth control pills? Type/Dose _____
☐ YES ☐ NO (2.) Are you pregnant? Due Date _____
☐ YES ☐ NO (3.) Have you recently : - delivered? Date:_____ - miscarried? Date: _____

DISPOSITION

☐ YES ☐ NO Fit for incarceration ☐ YES ☐ NO Refer for Medical evaluation
☐ YES ☐ NO Refer for Mental Health evaluation ☐ YES ☐ NO Other (describe) _____
COMMENTS: _____

NO ACUTELY ILL PERSON IS TO BE ACCEPTED INTO THE FACILITY

OFFICER'S/NURSE SIGNATURE_____ BADGE NO. _____

ARRESTEE'S SIGNATURE _____